1.0 Purpose:

To assure care provided to each patient is based on an assessment of the patient's relevant physical, psychological and social status needs resulting in care that the patient is seeking in the best setting possible.

2.0 Scope:

All Patients at Apollo Hospitals, Secunderabad

3.0 Definitions & Abbreviations:

IDT	-	Interdisciplinary Team
MBBS	-	Bachelor of Medicine and Bachelor of Surgery
MHC	-	Master Health Check
MRD	-	Medical Records Department
SOP	-	Standard Operating Procedures

4.0 Responsibility:

Hospital Administrator, Deputy Medical Superintendent, Consultants, Nursing Staff and every other care provider

5.0 Policy:

5.1 Each patient upon admission to Apollo Hospitals, Secunderabad shall be assessed by qualified individuals for appropriate care or treatment needs / need for further assessment. The physical, psychological, social and economic status of each inpatient shall be assessed. The scope and content of assessment shall be defined by a multidisciplinary Committee (Nursing Assessment, Inpatient History and Physicals, Nutritional Screening Assessment, Physiotherapy Assessment, Medical Social Worker's Assessment, etc).

5.2 The scope and content of the assessment shall be determined by:

a) The patient's condition/diagnosis
b) The care setting
c) The patient's response to any previous care and
d) The patient's consent to treatment.

5.3 The patient shall be assessed and the records shall be documented as appropriate to the patient's age and needs.

5.4 Outpatient assessment - the Physician shall assess outpatients during the clinic visit.

5.5 The physician as deemed appropriate for patient condition shall perform follow-up visit assessments.

In the initial assessment, patients with pain shall be identified so that they may receive appropriate treatment or referral.

5.6 A duly registered and credentialed staff Physician shall either perform or supervise the performance of a patient initial assessment within 24 hours. Initial assessments shall be valid for 30 days.

5.7 In emergency room the patient shall be assessed by the emergency room team immediately on arrival and documentation shall be completed. In the mean time the patient shall be given appropriate treatment to stabilize him/her. The concerned doctor shall be immediately informed about the patient arrival.

5.8 The nursing assessment shall be performed and documented in the patient record within 24 hours of admission.

5.9 The nutritional and functional assessment shall be completed within 24 hours of admission of the patient.

5.10 Continued assessments and reassessments shall be documented throughout the patient's medical record. A multidisciplinary approach shall be utilized for performing patient assessments based on the patient's diagnosis and the care setting and the patient's response to any previous care, i.e., by Physicians, Nursing staff, Nutritionist, Physiotherapist and Medical Social worker. This shall be performed in the interdisciplinary team rounds and documented in the IDT form.

5.11 The initial medical assessment shall be documented before anesthesia or emergence treatment, which shall also include a re-evaluation immediately before administration of anesthesia.

5.12 Reassessment of the patient shall be performed at regular intervals in the course of care by medical and nursing staff.

A. Reassessments shall be performed to determine a patient's response to care/treatment.

B. Reassessment shall take place also when there is a significant change in a patient's condition or a change in diagnosis. Reassessments shall also depend on the type of patient population.

C. Nursing staff shall reassess patients as per the standards maintained in the department.

D. Medical staff shall reassess patients once daily, including weekends, during the acute phase of their care and treatment.

E. More frequent reassessments shall be done by both nurses and doctors as per the clinical condition of the patient.

5.13 Assessment and reassessment are documented in the following reports:

A. Medical Staff:

1) Progress Record
2) Pre/Post Anesthesia Record
3) Consultation Referral
4) Operative Reports
5) Discharge Summary

B. Nursing Staff:

1) Nursing Assessment & Care Plan
2) Nurse' Record
3) Nurse's Clinical Chart
4) Flow Sheets

C. Nutritional services, Physiotherapy services as appropriate. Other assessments are performed and documented.

5.14 The plan of care shall include preventive aspects of the care and shall be reviewed regularly in consultation with or from written information provided by other members of the health care team and the patient/family. The plan of care shall be revised as appropriate to the patient's condition and the ongoing assessment process.

Information about the patient's care and response to treatment shall be shared among medical, nursing and other care providers during each staffing shift, between shifts and during transfers. The patient's record shall be available to the authorized care provider to facilitate exchange of information.

Discharge planning needs shall be included in the initial assessment and reassessment process, throughout the patient's hospitalization. The patient family shall be involved in the discharge planning process as appropriate.

Responsibility Matrix - Initial Assessment of the patient

Initial assessment	Reception staff	Registered medical practitioner (Consultant / Registrar / Resident Doctor)	Nurse	Dietician
After Admission – Medical		•		
Nursing			•	
Nutritional		•		•
Functional			•	

Responsibility Matrix - Reassessment of the patient

Reassessment	Registered medical practitioner (Consultant/Registrar/Resident)	Nurse	Dietician
Medical	•		
Nursing		•	
Nutritional			•
Functional	•	•	

Assessment of patient documents

Assessment	Document
Medical	Initial Patient Assessment, Progress Record, In House Transfer Forms, Pre-Operative assessment (Physician), Restraint Form, Emergency – Accident and Emergency forms
Social, Economic and Psychological	Initial Patient Record at registration
Nutritional	Nutritional Assessment Form
Nursing	Nurses Record, Flow Sheets, Nursing Assessment & Care Plan
Pre-anesthetic, Intra operative and Post operative	Surgical Record-Anesthesia Record

Qualified professionals perform assessment are Registered as applicable under the law of the land:

Professional	**Basic Qualification**	**Registration**
Medical	M.B.B.S	Registered with the Centre / State Medical Council
Nursing	Diploma / Degree in Nursing	Registered with the Centre / State Nursing Council
Dietician	Master's Degree in Dietetics	Not required
Counselor	Master's Degree in Social work	Not required
Physiotherapist	Bachelor's Degree in Physiotherapy	Not required